Statement of Sheldon L. Goldberg
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Good Morning, Senator Grassley, Senator Breaux, and members of the committee. I am Sheldon Goldberg, the President of the American Association of Homes and Services for the Aging (AAHSA). On behalf of the American Association of Homes and Services for the Aging (AAHSA) I am pleased to present testimony that addresses quality concerns in California's nursing facilities. I commend the Senate Special Committee on Aging for your continuing attention to the needs of the elderly, and particularly those in nursing homes. The issues presented by the report of the Government Accounting Office, which is the subject of this hearing, point out that we are not there yet in our efforts to guarantee quality care to every nursing home resident. AAHSA welcomes the opportunity to provide input and comments to the Committee about how we may reach that goal together.

AAHSA is a national non-profit organization representing more than 5,000 not-for-profit nursing facilities, continuing care retirement communities, senior housing facilities, assisted living and community-based organizations. More than half of AAHSA's membership is affiliated with religious organizations; the remaining members are sponsored by private foundations, fraternal organizations, government agencies, unions, and community groups. With our broad range of facilities and services, AAHSA members serve more than one million older persons daily. For the past thirty-six years, AAHSA has been an advocate for the elderly and for a long-term care delivery system that assures all those in need of high quality services and quality of life. Our membership has a longstanding commitment to meeting the needs of the individuals we serve in a manner that enhances their sense of self-worth and dignity.

The GAO report which is the subject of this hearing was prepared to look at the question of whether serious quality problems exist in some California nursing homes. Based on what it acknowledges was a small sample, GAO did document a number of problematic situations. However, AAHSA believes that any broad-brush portrayal of long-term care, or even of the long-term care regulatory system, from this sample would be misrepresentative. For that reason, AAHSA would like to provide a context from which to view the GAO findings.

Additionally, we would like to point out to the Committee that we had an opportunity [under somewhat restrictive conditions] to briefly review the GAO's findings. AAHSA staff was allowed to read the report at GAO offices here in Washington, D.C. We were not premitted to retain copies of the report or notes of our observations. We did provide some initial reactions and comments to staff of the GAO based on this initial reading.

Senator Grassley, in your invitation letter to testify before the Special Committee, you asked that we address the findings of the GAO study. Obviously, a thorough treatment of the major findings and recommendations of the report is most difficult considering the conditions imposed on us. We respectfully request that the Committee give us the opportunity to add to and/or amend this written testimony after we have a chance to more completely study and evaluate the report.

OBRA '87 and Current Regulation of Nursing Facilities

The nursing home quality reform provisions of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) enacted the most sweeping changes to nursing facility operations since the passage of Medicare and

Medicaid. AAHSA strongly supported the passage and implementation of OBRA. We were one of the initial members of the Campaign for Quality Care, the coalition of organizations coordinated by the National Citizens' Coalition for Nursing Home Reform (NCCNHR), that worked to reach consensus on twelve key areas of nursing home reform. AAHSA has continued to serve on various committees and workgroups convened by the Health Care Financing Administration to work toward a reasonable and equitable implementation of the regulations and interpretive guidance resulting from the OBRA requirements. We are currently working with HCFA on the agency's most recent long term care initiative, *Sharing Innovations in Quality,* an effort to establish an easily accessed central repository for innovative practices in long term care. As a national association we have remained an advocate for the presence of federal standards because we believe that many of the policies and care practices of our members have been enhanced as a result of these provisions.

One of the most significant transformations resulting from the passage of OBRA '87 was the shift in focus of regulatory oversight from facilities' capacity o provide care, "paper compliance" with requirements, to one on resident outcomes, that is, the actual care provided.

Several of the nursing home quality reform provisions and resulting federal regulations have facilitated this change in approach and have worked to improve the quality of care and assure better resident outcomes.

1. Standardized Resident Assessment (RAI/MDS)

Central to the OBRA '87 change from process to outcomes is the mandate that every facility conduct "...initially and periodically, a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity." These assessments are to be interdisciplinary in nature, to be conducted at least annually, reviewed quarterly, and revised in the event of a significant change in status. The resident assessment instrument and minimum data set (RAI/MDS) developed under the auspices of the Health Care Financing Administration (HCFA) as a result of OBRA '87 has been successfully implemented on a national basis and has been revised (MDS 2.0) to provide further clarification and increase its clinical effectiveness.

Included in the 18 domains that comprise the RAI/MDS is a section assessing oral and nutritional status. This section is intended to identify specific problems, conditions, and risk factors related to malnutrition. As with the other areas of assessment, those residents identified through the MDS as being at risk for nutrition related problems, including the problem of pressure sores identified in the GAO report, are subject to a more in-depth evaluation to identify reversible or treatable causes of these problems. The results of this assessment process provide the basic guidance for the development of a care plan.

As of June 22, 1998, the MDS data collection and transmission process has been computerized through a nationwide system. HCFA now is implementing a national database to serve as a repository for this information. This database will allow HCFA to compile individual resident profiles, to link individual assessments longitudinally, and to monitor outcomes in terms of both improvement and decline. It will also be used to develop performance standard norms or "quality indicators." The ability to track individual and collective resident outcomes on a longitudinal basis will permit the Administration to target its oversight resources on facilities providing less than optimal care. With its planned "feedback loop" to providers, the MDS database also has the potential to serve as an effective internal quality assurance and management tool for long term care facilities. When the database is fully functional, both providers and regulators alike will be able to spot the problem areas identified by GAO more readily.

2. Highest Practicable Physical, Mental, and Psychosocial Well-being

OBRA '87 also placed nursing facilities in the unique position of being the only health care provider to be mandated to guarantee specific resident or patient outcomes. Under requirements for both Resident Assessment (CFR 483.20) and Quality of Care (CFR 483.25), nursing facilities must "provide and assure that each resident receives the necessary care and services to attain and maintain [his/her] highest practicable physical, mental, and psychosocial well-being." The interpretive guidelines for these requirements (HCFA State Operations Manual Transmittal #274) state that "Facilities must ensure that each resident obtains optimal improvement or does not deteriorate [within the limits of the resident's right to refuse treatment, and within the limits of recognized pathology and the normal aging process]."

This language not only assures that resident outcomes will be stressed as a measure of quality of care, but also places a clear responsibility on nursing facilities not just to maintain the status quo, but to act aggressively to improve the resident's health status.

3. Staffing requirements

OBRA '87 eliminated the prior staffing distinction that existed between Intermediate care facilities (ICFs) and skilled nursing facilities (SNFs). This means that all nursing facilities are now required to have twenty-four hour licensed nursing staff and a registered nurse for at least eight hours a day, seven days a week.

In keeping with the statutory intent to focus on outcomes rather than process, the current Requirements for Participation for Long Term Care Facilities, promulgated as a result of OBRA '87 do not mandate staffing ratios, but require that facilities have "sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident .....

In developing the nursing home quality of care provisions, Congress also recognized the magnitude of care provided by nurse aides. Nurse aides employed by facilities are required to meet minimum training and competency evaluation requirements. Facilities are prohibited from using any individual as a nurse aide for more than four months on a full-time basis, unless that individual has successfully completed at least a 75-hour training and competency evaluation program, (NAT/CEP) or a competency evaluation program, approved by the State.

Outcomes vs. Staffing Ratios

From time to time the suggestion has been made that OBRA '87 be amended to establish specific nursing care staffing ratios for nursing facilities. Even though not-for-profit facilities traditionally staff at higher levels, AAHSA would strongly oppose such an approach for several reasons.

First, both the provider and consumer communities have long supported the shift from process to outcomes as a means of assessing quality of care. Any attempt to assure the provision of optimal care based on mandated nursing care staffing ratios would defeat all of the efforts that have been made within both the legislative and regulatory arenas to achieve this goal. Additionally, any assumptions of quality based on numbers of nursing care staff and nursing hours rather than on efficient use of nursing care staff and resident outcomes is simplistic and potentially deceptive.

Second, while too little staffing will certainly lead to poor outcomes, there has never been any proven correlation between higher staffing levels and the guarantee of positive outcomes.

Third, inherent in any mandate for staffing ratios is the danger that the minimum will become the

maximum. This scenario is even more likely in the managed care environment and the accompanying climate of cost containment.

Finally, a mandate for staffing ratios discounts the growing role of technology in nursing facilities. One example that can be cited from the past is the Hoyer Lift. Prior to its development, two nurses or nurse aides would be needed to lift one resident. With the Hoyer lift, this task can be performed by one nurse or aide, cutting the number of required staff by half. The raises the question whether staffing ratios would have to be recalculated every time a new mode of technology is developed that can substitute for, and possibly perform better than, human intervention.

OBRA '87 and the Federal regulatory system already assure adequate protection for residents through requirements that facilities have the appropriate level of staff to enable residents to function at their highest practicable level. Failure to comply with these requirements subjects nursing facilities to State and Federal enforcement actions. Any farther specification of staffing numbers or ratios would be excessive and would undermine the focus on resident outcomes as an effective barometer of care.

The existing regulatory system for ensuring quality in nursing home care contains all of the tools that the federal and state governments need to make sure that nursing facilities are staffed appropriately. Rather than prescribing arbitrary and inflexible staff ratios, the existing regulations mandate favorable outcomes for nursing facility residents, and that each resident reach and maintain his or her highest practicable physical, mental, and psychosocial well-being. This requirement constitutes a higher standard of care than staffing ratios would be likely to achieve. It is the standard by which nursing facilities already are being evaluated, and we believe that facilities should continue to be held to this standard.

Nurse Aide Shortage

AAHSA firmly believes that mandated staffing patterns numbers are contrary to an outcomes-based assessment of care. However, we do not dismiss the argument that a poor resident outcome can result from a shortage of staff, particularly nurse aides. The GAO report suggests that short staffing may have contributed to some of the problems cited.

We acknowledge that one of the key challenges faced by nursing facilities is the ongoing shortage of nurse aides - a shortage that has been exacerbated in recent years by the downsizing of professional staff and increased use of paraprofessionals in acute care, as well as the growth in demand for aides in home health care. Because of the competency evaluation and certification associated with the NATCEP, it has become increasingly attractive for providers from other care settings to recruit and hire nurse aides trained and certified under the requirements for nursing facilities.

While nursing facilities have been working to enhance the functions of the nurse aide, including greater development of career ladders, home health agencies and hospitals are frequently able to offer greater flexibility in scheduling and/or higher wages. The result is that aides are being trained and certified in nursing facilities, and then moving on to apply their skills in other settings. Thus, while higher acuity levels among nursing facility residents, as well as projected aging demographics, point to a demand for paraprofessional staff in nursing facilities that will continue to escalate, nursing facilities find themselves in the untenable position of seeking to fill these positions from an already limited labor pool that is currently being drained by acute and home care providers. Given the status of state and federal payments to nursing homes, our ability to compete with hospitals and home health agencies is minimal. The irony, of course, is that long-term care--arguably the most poorlyfunded component of the health system--is actually subsidizing those providers which are not required to bear the cost of training their

personnel, as are we.

Specialized Training

AAHSA has proactively worked to alleviate the shortage of nurse aides and has developed a proposal to respond to this issue under some limited circumstances. As stated above, nurse aides are subject to mandated training requirements and competency evaluation. In the nursing home environment, many employees who are neither nurse aides nor licensed health professionals also have frequent and regular contact with residents, either by personal choice or as an integral part of their job. Permitting these individuals to perform tasks determined to be non-nursing-related may offer some relief to the nurse aide shortage without compromising the health and well-being of the resident.

Three areas of potential non-nursing employee assistance have been identified. Assistance with eating is probably the most frequently cited, but others include transporting and mobility, and activities. Allowing non-nursing employees to provide assistance would be based on the needs and potential risks to the individual, as identified in the comprehensive assessment and determined by the licensed nurse responsible for the resident. For example, assisting a resident with a swallowing problem to eat would be considered nursing-related, while helping an alert and competent resident with a paralyzed or immobilized arm would not. Personnel performing non-nursing-related tasks would be required to complete relevant in-service training approved by the regulatory authority and demonstrate competence in the duties assigned. AAHSA has developed legislative language to permit delegation of non-nursing tasks. A copy of our proposal is attached.

4. Reimbursement

Most nursing facilities and their residents are heavily dependent on the Medicaid program, which pays for over half of the total cost of nursing home care nationwide. Medicare covers relatively little long-term care, and few nursing home residents have private insurance that covers the cost of their care. Residents who have any financial resources pay for their nursing home care out of pocket. Once their resources are exhausted, they qualify for Medicaid coverage.

Medicaid reimbursement rates for nursing facilities often are not set according to the cost of providing care, but according to what the state feels it can afford. Medicaid rates therefore are often substantially below actual costs. Although AAHSA would never argue that high rates automatically result in high quality, few could dispute that dismal payments eventually result in unsatisfactory care. For the record, we note that California ranks 46th of the 50 states in nursing home Medicaid expenditures per capita - this in a state that ranks 12th in personal income. California has clearly made a decision that long-term care is not a high priority.

This problem will be exacerbated by the repeal of the Boren Amendment under the Balanced Budget Act. The Boren Amendment used to require that Medicaid reimbursement bear a reasonable relationship to the actual cost of efficient and effective care in a nursing facility. Facilities had recourse to the courts if reimbursement levels fell too low, and the fact that facilities frequently prevailed in these cases indicates how often states have tried to cut comers on nursing home reimbursement because of other budget priorities.

We stated earlier that many of the problems cited by the GAO report can be attributed to sta 9 issues. Nursing facilities cannot retain qualified staff unless we can pay them decent wages and benefits. It seems as though governments at all levels care about nursing home residents right up until it becomes time to pay for their care, and then state autonomy and balancing the budget are given greater weight.

Without the Boren Amendment, nursing facilities have little leverage to bargain with the states on reimbursement rates. We urge you to give renewed attention to this issue as you continue to examine the quality of care in nursing facilities. The Balanced Budget Act and its Medicare payment "reforms" add a whole new layer of reimbursement concerns for nursing homes which must be addressed as well. A prospective payment system that will take more than $12 billion out of Medicare SNF payments, new requirements for consolidated billing, and excessively stringent caps on therapies present frightening scenarios for the funding of long-term care.

Impact of OBRA '87

The purpose of the GAO study was to document the existence of bad care and instances where the system's response was inadequate or inappropriate, and it did so. The draft report also notes the limitations of this study and warns about generalizations to all facilities. It is therefore equally important to remember that there is another-positive---side to this story, and much of what is happening in nursing homes does not reflect the failure of the current system, but rather its success.

Since the implementation of OBRA '87 and the resulting federal regulations, several studies have found significant improvements in quality of care and resident outcomes in nursing facilities, including reductions in the use of psychotropic drugs and physical restraints. A 1995 study funded by the Health Care Financing Administration found significant reductions in decline [and need for assistance] among residents in activities of daily living, such as bathing, dressing, locomotion, toileting, transferring, and eating. The study also found a 26% decrease in hospitalizations among nursing home residents. This reduction reflects not only increased resident well-being, but also a positive impact on Medicare expenditures, yielding an estimated savings to the Medicare program in hospital costs alone of more than $2 billion per year in 1992 dollars.

In addition to the contributions made by OBRA '87, many voluntary innovations in quality are ongoing, as referenced earlier. Providers also are excited about ways to measure resident satisfaction with care. This spring we asked our members to send us copies of resident satisfaction instruments they currently are using. In a two-week period, we received 700 samples.

Yet, as GAO points out, even though state and federal enforcers have the tools they need to monitor care and respond to deficient care practices, we still see reports of bad conditions, such as avoidable malnourishment or pressure sores, in some nursing facilities. Rather than new laws or regulations to add to the already elaborate structure governing nursing facilities, we agree with GAO that these incidents indicate a need to restructure or refocus the Iong term care survey and enforcement process.

We would also like to take the opportunity to correct what we believe was a misunderstanding expressed by GAO in its report.

In the report the GAO refers to "amnesty" afforded to facilities under federal law once deficiencies are corrected, in the form of "forgiving" the noncompliance once correction is achieved. "Amnesty" is an inaccurate characterization of this process.

It is true that under current law that facilities with a good compliance history are given the opportunity to correct deficiencies within a given timeframe and defer imposition of a recommended sanction. A good compliance history is defined as no determinations of substandard quality of care within the current or previous two surveys. This deferral of a remedy is consistent with the intent of the law--to promote and support sustained compliance----rather than simply punishing facilities found to have a deficient care practice. It should be made very clear, however, that deferral of a sanction does NOT

negate or remove the deficiency citation. Failure to correct the violation results in imposition of the remedy. A repeat violation in this same or a related area on any subsequent survey will result in incrementally more severe civil monetary penalties and/or other available alternative remedies. This is not "amnesty" or "forgiveness" of the deficient practice or of the violation itself.

There are federal criteria for identifying those homes which do have a history of chronic or repeated noncompliance or which have provided substandard care as "poor performing facilities." These facilities do NOT have the "opportunity to correct" and are subject to the imposition of sanctions regardless of how quickly they come back into compliance. Under the law, failure to come into compliance within six months under any circumstance results in automatic termination from the Medicare and Medicaid programs. This process exemplifies the tools the system has available to respond to chronic or egregious noncompliance through the imposition of remedies in accordance with the scope and severity of the noncompliance.

Regulatory System Improvements

OBRA '87 mandates that all nursing facilities be surveyed on an annual cycle ranging from nine to fifteen months, with an average of twelve months. Surveys are an extremely time-consuming process for both nursing facilities and for the state surveyors, as they should be. Since all facilities must be surveyed within the confines of this timeframe, surveyors do not have the opportunity to focus their time and resources on the problem facilities that need more attention. Surveyors must spend as much time in facilities with a consistently deficiency-free record as they spend in facilities where the quality of care has been consistently poor.

Federal and state resources for surveying nursing facilities are not unlimited. The 1998 appropriations for the Department of Health and Human Services cut funding for these surveys by $4 million below the 1997 spending level. We do not expect any significant increase under the 1999 appropriations.

In recognition of the need to target more time and resources to problem facilities, the Health Care Financing Administration in 1996 began an attempt to streamline, without diluting, the long-term care survey process. While this initiative was squashed, we feel that it was a realistic effort to put more resources into dealing with facilities that have a history of providing poor care.

The nine- to fifteen-month range that OBRA '87 provided for survey cycles indicates a congressional intent to give surveyors some flexibility to inspect nursing facilities with differing frequency. AAHSA feels that the oversight process would be made much more effective if this flexibility were expanded to enable surveyors to inspect facilities with good records at intervals of up to two years. This expanded survey cycle would give surveyors the true flexibility they need to concentrate their time and attention on the facilities with records of poor care so that bad conditions are corrected and consiste tI bad facilities are shut down.

Conclusion

Based on our brief initial review of the report, we understand that the General Accounting Office made four recommendations, all of which AAHSA can support:

First, GAO recommends that the survey cycle be staggered so that nursing homes cannot predict the scheduling of surveys. The GAO also suggested that surveys be broken down into stages and conducted at different times during the 12-15 month period. Thus, the survey team might examine patient records during one visit, and physical plant during another. This procedure would prevent homes from making

improvements only when they thought surveyors were coming.

Second, GAO recommended that surveys inspect a random, stratified sample of resident records rather than the current targeted sample in order to get a better handle on deficiencies in each patient care area.

A third recommendation of GAO was the imposition of penalties for chronically poor performing facilities or for homes with a consistent substandard quality of care.

Fourth, GAO recommended that there be a revisit by HCFA or the State Survey agency after a substandard survey finding -- rather than simply allowing facilities to certify that they are back in compliance.

To these recommendations, AAHSA would add three others. First, we repeat our suggestion that surveyors be given the flexibility to extend the survey cycle for 24 months for good homes so that they can focus on rehabilitating or closing chronically bad facilities. In the past, some have argued against closing bad homes because of transfer trauma to residents who must be moved. We submit that almost no amount of transfer trauma approaches the pain of a Stage IV pressure sore. It's time to get the bad actors out, Mr. Chairman. We might disagree from time to time about which homes are the bad ones, but all surveyors know which ones are the worst. Let's start with those.

Our second recommendation is that government agencies start paying more attention to which facilities are initially licensed by the state and then certified for participation in Medicare and Medicaid. There is no reason to believe that multi-facility providers who give poor care in another state, or in another part of the same state, will give stellar care in a different facility. Data on nursing home performance is public. It is most certainly available to those who license or certify facilities. Requiring that a sponsor or investor provide **consistently** good care in order to expand its operations is a powerful incentive.

Last, Mr. Chairman, we believe it is time for a serious dialogue between the Congress, federal and state government agencies, residents and families, and providers about quality. OBRA '87 passed almost 11 years ago, and the new enforcement system has been up and running since 1995, but we are still arguing about whether we have enough regulations to promote good care. GAO has identified both providers and surveyors which appear to be guilty of poor performance. If GAO is correct in its assumption that the problems may be more extensive than its California examples, then we have a mutual problem. It is a problem that must be addressed, Senator. We believe that long-term care is going to be a more important part of the future health care system than anyone ever imagined it would be. We all must be prepared for that.

The situation as we see it was perhaps best captured by Msgr. Charles J. Fahey, director of the Third Age Center of Fordharn University in New York, in a paper on the ethical issues presented by the Balanced Budget Act. Msgr, Fahey stated,

We are a nation in denial. Decreasing mortality has the unintended but real secondary effect of increasing frailty in every age cohort, not just those at the end of life. Costly compensations must be made if those who have handicapping conditions, whatever the etiology or manifestation, are to have decency. Costs, monetary, psychological and or opportunity will be paid by someone. Who will pay the price of "development?" Currently most of the costs are incurred by the user and his and her family, though much is absorbed by providers.

Long term care ... has ceased to be on the policy agenda save as a cost cutting issue.

Mr. Chairman, we are asking that you put long-term care back on the policy agenda, and not just as a cost cutting issue.

Again, we thank you for this opportunity to share our views.